

# NORFOLK CHIROPRACTIC WELLNESS CENTRE

## MASSAGE THERAPY HEALTH HISTORY FORM

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The information requested below will assist us in treating you safely and effectively. Please note that all information provided below will be kept confidentially unless allowed or requested by law (your written permission will be required). If at any time you have any questions regarding your visit, please feel free to ask!

Name: \_\_\_\_\_ Phone#: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Where did you hear about our clinic? \_\_\_\_\_ Have you had a massage before?  Yes  No

What brings you in for a massage? \_\_\_\_\_

Overall, how is your general health? \_\_\_\_\_

Please indicate conditions you are experiencing or have experienced:

### CARDIOVASCULAR

Current/ Previous

- /  High Blood Pressure  
 /  Low Blood Pressure  
 /  Chronic Congestive-  
Heart Failure  
 /  Heart Attack  
 /  Phlebitis/ Varicose Veins  
 /  Stroke/ CVA  
 /  Pace Maker or similar device  
 /  Poor Circulation  
 /  Heart Disease

### RESPIRATORY

Current/ Previous

- /  Chronic Cough  
 /  Shortness of Breath  
 /  Bronchitis  
 /  Asthma  
 /  Emphysema  
 /  Breathing Problems

### HEAD/ NECK

Current/ Previous

- /  Headaches/ Type: \_\_\_\_\_  
 /  Vision Problems/ Loss  
 /  Earaches  
 /  Vertigo/ Dizziness  
 /  TMJ Dysfunction

### WOMEN

Current/ Previous

- /  Menstrual problems  
 /  Gynecological conditions  
What? \_\_\_\_\_

Pregnant?  YES  NO

DUE DATE: \_\_\_\_\_

Number of children: \_\_\_\_\_

### OTHER HEALTHCARE

Current/ Previous

- /  Massage Therapy  
 /  Chiropractic  
 /  Physiotherapy  
 /  Psychotherapy  
 /  Regular Exercise

### INFECTIONS

Current/ Previous

- /  Hepatitis  
 /  Herpes  
 /  Skin Conditions  
 /  TB  
 /  HIV/AIDS

### OTHER CONDITIONS

Current/ Previous

- /  Liver  
 /  Gall Bladder  
 /  Kidney/Bladder  
 /  Diabetes onset: \_\_\_\_\_  
 /  Insomnia  
 /  Cancer/where? \_\_\_\_\_  
 /  Epilepsy  
 /  Constipation  
 /  Digestive difficulties  
 /  Allergies/ Hypersensitivity  
What? \_\_\_\_\_  
 /  Loss of sensation  
Where? \_\_\_\_\_  
 /  Arthritis, or family history of?  
 Yes  No  
Affected areas: \_\_\_\_\_  
 Yes /  No Any internal pins, wires, artificial joints?  
Where? \_\_\_\_\_

### PREVIOUS INJURIES/SURGERIES

Nature: \_\_\_\_\_

Date: \_\_\_\_\_

Nature: \_\_\_\_\_

Date: \_\_\_\_\_

### CURRENT MEDICATIONS

\_\_\_\_\_condition\_\_\_\_\_

\_\_\_\_\_condition\_\_\_\_\_

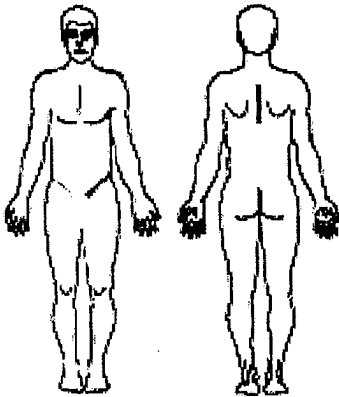
\_\_\_\_\_condition\_\_\_\_\_

PLEASE TURN OVER AND  
FILL OUT BACK OF FORM.....

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Please mark an 'X' on the picture where you feel discomfort.

Circle where you feel discomfort



Neck	Upper Back	Lower Back	Mid Back
Arms	Hands	Hips	Thighs
Lower Legs	Knees	Ankles	Feet
Chest	Abdomen	Head	Gluteals/buttocks
Other			

How long have you experienced it? \_\_\_\_\_  
 What tends to aggravate or relieve your pain? \_\_\_\_\_

**Informed Consent**

I understand that the purpose of massage therapy is to restore and maintain the integrity of the musculo-skeletal system. I understand that massage therapy is a hands-on health care discipline that will require the therapist to place his/her hands on those areas of the body that are involved in the cause of my symptoms. I am aware that my Therapist is a Registered Health Care Professional and has the right to discontinue the treatment at their discretion.

I understand that I have complete control of my own treatment and the right to change/alter, or discontinue the treatment at any time should I feel uncomfortable.

I understand that massage therapists do not diagnose illnesses, disease, or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary healthcare provider for that service.

I further understand that in the practice of massage therapy there is potential for mild side effects, including but not limited to, muscle soreness/point tenderness in areas worked (lasting up to 24-48 hours), mild bruising, headache, and possibly feeling lightheaded. Following the treatment feelings of fatigue are common. Cold packs on achy areas ( 10min on, 10min off) will help minimize any discomfort. Please feel free to call us at any time at the clinic if you have any questions or concerns.

**Fee is due at the time of treatment; cash, cheques, interac, visa, mastercard are accepted.  
 Without 24 hours notice you will be billed full price for your appointment.**

I \_\_\_\_\_ have read and acknowledge all of the above information and give  
 ( please print name)  
 my consent for massage treatment/assessment.

Signature: \_\_\_\_\_  
 (if patient is a minor, signature of parent/guardian)

Date: \_\_\_\_\_